REGISTRATION FORM
THE LASIK CENTER OF JACKSON

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)	Sex	Date of Birth	Marital Status	Age	Race	Social Security No.

Patient Address	City	State	Zip Code	Patient Phone No. ( )

Patient Employer	Occupation & Department

E-mail Address	Work Phone No ( )

SPOUSE / GUARDIAN / NEXT OF KIN INFORMATION

Spouse or Guardian (Last, First, Middle Initial	Relationship to Patient ☐ Spouse ☐ Guardian ☐ Parent	Alternate Phone Number

REFERRING DOCTOR INFORMATION

Referring Doctor Name	City	State

Medical Doctor Name	City	State

How did you hear about the LASIK Center of Jackson and our doctors?

Referral Source

LASER VISION CORRECTION FINANCIAL AGREEMENT

I understand the fee for Laser Vision Correction Laser Treatment is

CustomVue LASIK with BLADE **$1, 999.^{00} per eye**

Zeimer Laser-BLADELESS CustomVue LASIK **$2, 499.^{00} per eye**

The fee includes the pre-operative evaluation, laser treatment, facility fees and post-operative fees. You will be expected to pay **$150.00** on the day of your initial evaluation. This fee will be deducted from the total cost of your surgery.

Are you interested in financing Laser Vision Correction? YES or NO

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY: This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorneys fees and costs of collection in the event of default.

Like us on

_____ Date_____
Signature of Patient or Responsible Party

NOTICE OF PRIVACY PRACTICES / RED FLAGS RULE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you in the process of providing treatment, seeking payment or carrying out our own health care operations. This notice contains a Patient Rights section describing your rights under the law. A copy of the current notice in effect will be posted. Each time you receive treatment or healthcare services you may request a copy of the current notice.

Our Red Flags Rule Compliance Policies and Procedures provide information on safeguards in place to reasonably ensure protected health information and sensitive information related to identity theft.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

X_____ Date_____
Signature of Patient or Responsible Party

BREACH NOTIFICATION ACT

Under the HITECH Act passed in 2009, The Hughes Eye Center/ LASIK Center of Jackson will comply with the Breach Notification Rule. Patients will be notified of specified breaches of unsecured protected health information. This notification will occur in a timely manner and no less than 60 days from the date of the breach. Sign below to state you understand the previous statement.

X_____ Date_____
Signature of Patient or Responsible Party